The Utah Arthritis Advisory Committee &
The Utah Department of Health, Bureau of Health Promotion, Utah Arthritis Program

Utah's Arthritis Plan

Partnership to Increase the Quality of Life Among Persons in Utah Affeced by Arthritis

ARTHRITIS FOUNDATION®
Take Control. We Can Help.™

UTAH DEPARTMENT OF HEALTH
Arthritis Program

Utah Department of Health

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The Utah Arthritis Program in the Utah Department of Health, and the Utah Arthritis Advisory Committee are pleased to present **Utah's Arthritis Plan**. Arthritis and associated conditions have long been recognized as a significant burden to individuals and their families. Only recently, however, has attention been focused on the growing medical and social costs of these conditions.

Approximately one of every six Americans has been diagnosed with arthritis and it is the leading cause of disability. In Utah, approximately one of every five residents over the age of 18 has been diagnosed with arthritis. Importantly, many individuals with arthritis have not been diagnosed and therefore are not being treated by a physician for these conditions. When these individuals are considered with those who have been diagnosed, it is estimated that ***nearly one of every three Utah residents over the age of 18 meet the CDC criteria for arthritis***.

Utah's Arthritis Plan was produced through the collaborative efforts of many individuals and organizations. It represents a coordinated call to action that will challenge us to work as community partners towards a common cause. By striving to achieve the goals, objectives, and strategies presented in this plan, we hope to achieve the mission of the Utah Arthritis Program: ***To increase the quality of life among persons in Utah affected by arthritis***.

Utah's Arthritis Plan presents strategies towards achieving this mission in four sections: 1) Increasing Community Awareness; 2) Measuring Arthritis Trends; 3) Improving Clinical Practice; and 4) Promoting Supportive Health Systems and Policies. Experts in each of these areas have contributed to and reviewed this plan. It is through their cooperation and continued collaboration that we may succeed in these efforts. The Utah Department of Health extends its sincere appreciation to these individuals and organizations for their expertise and contribution.

Sincerely,

Scott D. Williams, MD, MPH
Deputy Director

Richard Bullough, PhD
Director, Utah Arthritis Program

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Partnerships to Increase the Quality of Life Among Persons in Utah Affected by Arthritis

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Table of Contents

INTRODUCTION

Welcome to Utah's Arthritis Plan. This plan was written with two purposes in mind, and therefore is presented in two sections. In *Section One*, we provide general information about arthritis, in the United States and in Utah. We are pleased to present in this section Utah-specific data on arthritis prevalence, burden, and risks. In *Section Two* we discuss the Utah Arthritis Program and present a "plan of attack"…what we intend to do to lessen the burden of arthritis in Utah. This section includes goals, objectives, and strategies for four key areas: 1) increasing community awareness; 2) measuring arthritis trends; 3) improving clinical practice and; 4) promoting supportive health systems & policies.

The term arthritis has various meanings. Throughout this plan, it refers to over 100 diseases and conditions that primarily affect the joints, surrounding tissues and other connective tissues of the body. In addition, it refers to chronic joint symptoms which include a combination of pain, aching, stiffness and swelling in or around a joint that is present on most days for at least one month, in the past 12 months.

These diseases and conditions include osteoarthritis, rheumatoid arthritis, systemic lupus erythematosus, gout, fibromyalgia, juvenile rheumatoid arthritis, and bursitis. The most common forms of arthritis are osteoarthritis, rheumatoid arthritis and fibromyalgia.

The data highlighted in this report are presented in detail in ***Utah's Arthritis Report***. This report may be obtained from the Utah Arthritis Program at the Utah Department of Health.

SECTION ONE: THE BURDEN OF ARTHRITIS

BURDEN OF ARTHRITIS IN THE NATION

Arthritis and related conditions affect almost 43 million people, or nearly one of every six Americans, making it one of the most common conditions in the US. By the year 2020, it is expected to affect an estimated 60 million Americans, or almost 20% of the population. It should be noted that these numbers are conservative. They reflect those diagnosed with arthritis and may not represent those with chronic joint pain who have not been told by a physician that they have arthritis.

The number of persons 18 or older reporting disabling conditions increased from 49 million during 1991-1992 to 54 million during 1994-1995. Of these 54 million adults, 41 million reported their main health condition associated with their disability. Of these persons, 7.2 million or 18% reported their main health condition associated with their disability was arthritis or rheumatism. Women had higher rates (22%) of arthritis or rheumatism than men (11%) By the year 2020, nearly 12 million people will experience activity limitations due to arthritis.

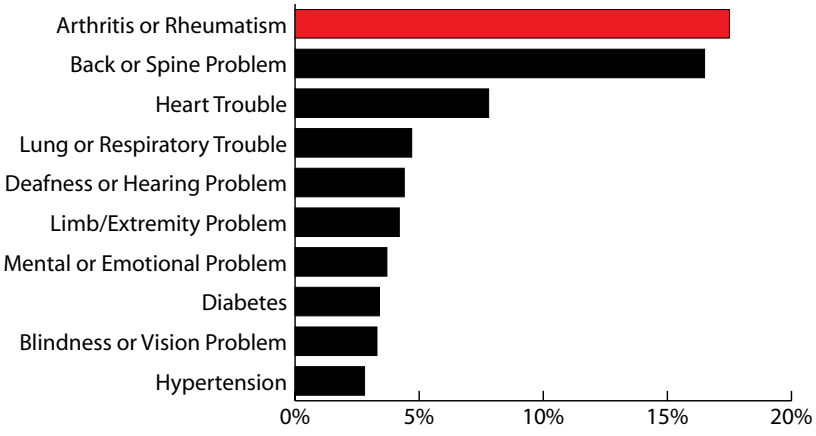
In addition, arthritis creates enormous costs for individuals and their families. In 1997, arthritis was the source of 44 million visits to a health care provider, 744,000 hospital admissions, and 4 million days of hospital care. In 1992, estimated national medical care costs for people with arthritis were $15 billion annually, and total costs (medical care plus lost productivity) were $65 billion.

BURDEN OF ARTHRITIS IN UTAH

The Behavioral Risk Factor Surveillance System (BRFSS, a telephone survey given to individuals 18 years and over), and Utah Hospital Discharge Data have been used to describe the burden of arthritis in Utah.

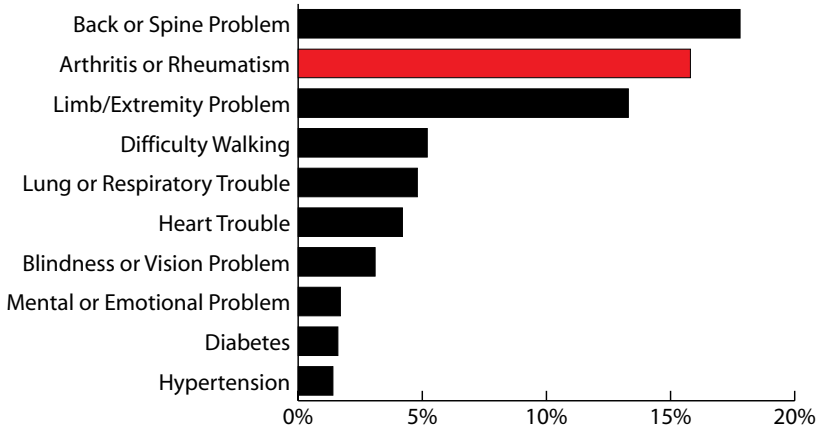
In Utah, approxamately one of every five residents over the age of 18 has been diagnosed with arthritis. Importantly, many individuals with arthritis have not been diagnosed and therefore are not being treated by a physician for these conditions. When these individuals are considered with those who have been diagnosed, it is

Figure 1. Leading Causes of Disability Among Persons 18 and Older
United States, 1999



estimated that ***approxamately 450,000 individuals, or nearly one of every three Utah residents over the age of 18 have arthritis.*** It is likely that arthritis prevalence and burden in Utah will increase in the future, as it is projected to do Nationally. The leading causes of activity limitation in Utah are similar to the causes of disability in the Nation.

Figure 2. Leading Health Problems that Limit Activity Among Utah Adults Who Limited Their Activities



BRFSS data* (year 2000 Utah survey) indicate that:

- Over 30% of Utah residents over age 18 have arthritis, and nearly one-third of these are undiagnosed
- Nearly three-fourths of Utah residents who have arthritis are under age 64
- More Utah women than men have arthritis (35% vs. 27%)
- Persons with arthritis are ten times more likely to report that pain limited their activities for 15 to 30 days in the past month than are persons without arthritis

Hospital discharge data provide further information about high medical costs associated with arthritis treatment in Utah. 1998 hospital discharge data indicate that:

- Total arthritis inpatient charges in Utah were $122,501,760 ($40,176,000 of this was for knee replacement surgery)
- The majority of those being treated for arthritis in the hospital were female
- Over 80% of those being treated for arthritis in the hospital were over 55 years of age
- The average length of stay in the hospital was four days

It is important to note that these dollar amounts only reflect costs associated with inpatient procedures and knee replacement surgery. They do not include all pharmacy costs, other medical care expenses, disability, or lost wages.

LESSENING THE BURDEN OF ARTHRITIS IN UTAH

To have a significant impact on arthritis burden in Utah, we must first assess the true prevalence, medical, and social costs of these conditions. A strong start has been made through the implementation of the BRFSS survey Arthritis

* Please note that in all graphs which refer to BRFSS data, the term *arthritis* refers to persons with CJS and/or doctor diagnosed arthritis.

and Quality of Life modules. These efforts will continue. Also, we must strive to further describe the burden by surveying providers of care and those with arthritis, by examining hospital discharge, medical claims, pharmacy, and other sources of data. Communication efforts must be implemented and refined to impact arthritis community awareness. Successful programs, such as the Arthritis Foundation's Arthritis Self-Help Courses, must be promoted and expanded. Also, increased physical activity and reduced prevalence of overweight and obesity must be encouraged. Professional education and quality improvement must be a part of these efforts. Any program that does not include the providers of care will likely fail. Health systems interventions must be developed to encourage quality improvement in arthritis care and to expand existing education programs to those who need them most. And, of course, partnerships in the public and private sectors must continue to be identified and strengthened so that services and programs are made available to everyone that needs them.

ARTHRITIS RISK FACTORS IN UTAH

Although everyone is at risk for arthritis, certain factors are known to increase the risk. The primary factors that can't be modified include older age, female gender, genetic predisposition, and ethnicity. In addition, other factors that may contribute to arthritis include: lower levels of education, lower income, overweight and obesity, inactivity, joint injuries, infections, and certain occupations.

Presented below are data from the Utah BRFSS survey. These data focus on prevalence and risk in Utah residents and suggest areas where Utah arthritis resources should be focused.

Age

Prevalence of arthritis increases with age in men and women, doubling in each successive age group from 18-64. Persons who are 65 or older are almost five times as likely to have doctor-diagnosed arthritis or chronic joint symptoms, when compared to persons 18-34 years-of-age.

Gender

Women are more likely to have arthritis or chronic joint symptoms. Among Utah females, 35% have arthritis or chronic joint symptoms, compared to 27% of Utah males.

Race and Ethnicity

Arthritis or chronic joint symptoms affects all races and ethnic groups. However, in Utah white non-Hispanics (30%) may be more likely to have arthritis or chronic joint symptoms than Hispanics (25%) or non-white Hispanics (27%). Nevertheless, culturally appropriate education programs may impact the quality of life for Utah's racial and ethnic populations.

Education

Lower education status may be related to increased arthritis prevalence in Utah, although this influence appears to be small. Among Utah residents with a 12th grade education or less, 31% have arthritis or chronic joint symptoms compared to 26% of college graduates. However, it appears that those with arthritis and less than a high school education suffer far more health problems due to arthritis than

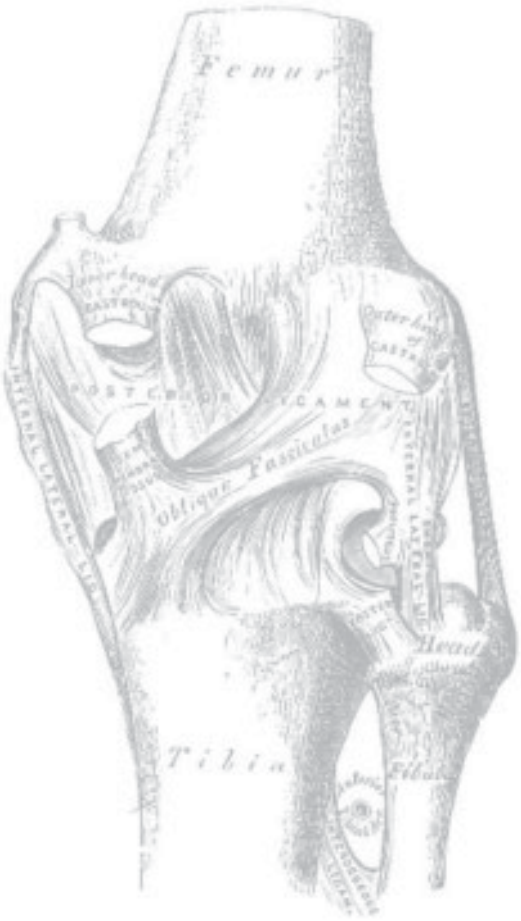
those individuals with arthritis and a college education.

Overweight and Obesity
Maintaining an appropriate weight lowers a person's risk for arthritis. Obesity is a risk factor for osteoarthritis of the knee and gout and is associated with increased pain in weight-bearing joints. Utah residents who are obese are 1.6 times as likely to have arthritis or chronic joint symptoms as people with normal body weight.

Physical Activity
For persons with arthritis, regular physical activity may help keep arthritis discomfort at a minimum. Additionally, inactivity may lead to increased arthritis prevalence. In Utah, 38% of adults with arthritis or chronic joint symptoms are physically inactive. Also, physical inactivity may put them at risk for other conditions, including heart disease, high blood pressure, overweight, depression and anxiety.

TARGET POPULATIONS

Using Utah-specific arthritis data, target populations may be identified so that resources are focused where they may do the most good. Clearly, men and women aged 40 to 64 years suffer a significant and rapid increase in arthritis prevalence. Further, women in this age group suffer the greatest arthritis burden. Therefore, many efforts described in this plan will focus on women in this age group. It is also clear that seniors suffer a high prevalence of arthritis and that the outcomes associated with these conditions can be severe. Efforts must be made to reach large numbers of seniors in ways that reduce the burden on them. Also, because of the very large expanse of rural lands in Utah, efforts must be made to impact arthritis care in rural communities. Additionally, it is critical that populations with special needs and ethnic and minority populations at risk be identified. While arthritis may not be more prevalent in these populations, appropriate education materials and program delivery will optimize program success in these populations.



UTAH DEMOGRAPHICS

Utah's population reached 2,233,169 in 2000, an increase of 510,319 (29.6%) since 1990, according to the U.S. Census Bureau. This represents the fourth highest growth rate in the nation during that period. In 2000, the estimated median age in Utah was 28, with 21% between the ages of 18 and 29, 14% between the ages of 30 and 39, 24% between the ages of 40 and 64, and 8.5% are 65 and older.

Utah consists of 29 counties covering 84,916 square miles. Most (76%) of Utah's residents live in the four urban counties of Davis, Salt Lake, Utah and Weber. The remainder of the state's population is spread out over 96% of the state's land area in 25 counties that are designated as either rural or frontier. Sixteen of these counties are designated as frontier counties and have a population density of fewer than six persons per square mile and nine are rural counties with six to 100 persons per square mile. Because of the contrast in Utah's population density, 26 of 29 Utah counties qualify as Health Professional Shortage Areas and 14 counties are designated as Medically Underserved Areas or counties with Medically Underserved Populations.

Residents of these rural and frontier counties tend to be poorer and are less likely to have health insurance than urban residents. Approximately 9% of households in rural and frontier counties reported annual incomes below $15,000 compared to 5.9% of households in urban counties. Almost 12% of residents in rural and frontier counties were without health insurance compared to 8.9% of residents in urban counties.

60.8% of Utah residents are enrolled in non-governmental managed care plans and 5.9% of residents are enrolled in governmental managed care plans such as Medicare and Medicaid. Of those enrolled in non-governmental managed care plans, 38.7% are enrollees of preferred provider organizations. Traditional indemnity plans cover only 14.2% of all Utahns. Nine percent of Utah residents are uninsured and the remainder use non-managed Medicare (8.3%) or Medicaid (1.7%).

Income estimates from 1996-1998 indicate that 7.7 percent of Utah residents have incomes below the federal poverty level. With a 1999 per capita income of $23,288, Utah ranked 41st out of the 50 states.

Utah's racial population is not diverse. In 1999, 95.1% of the population was white, 2.6% was Asian or Pacific Islander, 1.4% was American Indian or Alaskan Native and 0.9% was Black. 7.1% were of Hispanic origin.

Utah has 12 independent local health departments, which provide a wide range of services from personal health to environmental quality. They also provide some primary care services, but most of their efforts are directed at promoting health and reducing disease. They receive funding from local, state and federal governments and through contracts with the Utah Department of Health (UDOH).

SECTION TWO: THE UTAH ARTHRITIS PROGRAM, AND STRATEGIES TO IMPACT THE BURDEN OF ARTHRITIS IN UTAH

UTAH ARTHRITIS PROGRAM

The Utah Arthritis Program was established in October of 1999. At this time, 37 states received funding from the CDC to begin state-based arthritis programs. Of these 37 states, eight were established as "core states" and they received a higher level of funding. As a core state, Utah is focussing on the key components of the National Arthritis Action Plan: Increasing community awareness, measuring arthritis trends, improving clinical practice, and promoting supportive health systems & policies. The program is within the Bureau of Health Promotion, Division of Community and Family Health Services, Utah Department of Health (UDOH). There are six positions funded (full or part) by the Utah Arthritis Program grant. These include three full time positions: a program director, a community health specialist, and an epidemiologist. Also, there are three positions, which receive minor funding from this grant: a statistician located in the UDOH, a program specialist located at the Arthritis Foundation (Utah/Idaho Chapter), and a community health educator located at a local health department. In addition to these positions, there are numerous in-kind partners that are critical to the effort.

Partnerships

The success of Utah's Arthritis Plan is dependent on partners and partnerships. These include those with other departments and programs within the UDOH and those outside of the UDOH. By establishing partnerships, and working with these partners to identify needs, resources and expertise, and coordinating the delivery and evaluation of these resources, the Utah Arthritis Program intends to implement an effective and sustainable arthritis plan.

Within the UDOH, partnerships include those with other public health programs that share disease risks and/or target populations with those identified in this plan. For example, the Utah Cardiovascular and Diabetes Programs share target populations and health risks, such as obesity and physical inactivity, with the Utah Arthritis Program. Another example is the Utah Cancer Control Program, which focuses largely on women aged 40 to 64 years, a population also at high risk for arthritis. These programs must partner to impact the common risks associated with these chronic conditions in a way that optimizes the benefit while minimizing the cost. Two other partnerships of critical importance are those with the Center for Health Data and Rural and Ethnic Health. These programs bring important resources and expertise that will allow the Utah Arthritis Program to focus resources appropriately and effectively.

Partners outside of the UDOH are also critical to the success of this plan. These include individuals and organizations representing: the Centers for Disease Control and Preven-

tion, providers of care and services, persons with arthritis, local health departments, managed care and insurance, seniors, hospital organizations, academics and research, the local peer review organization, Medicare and Medicaid, the business community, and other individuals with arthritis interests. While all of these partnerships are critical, that with the Arthritis Foundation (Utah/Idaho Chapter) warrants special mention. Together with the UDOH, the Arthritis Foundation Utah/Idaho Chapter was instrumental in the funding and establishment of the Utah Arthritis Program. The Arthritis Foundation education and self-help programs play a critical role in reaching the community awareness and arthritis self-help goals laid out in this plan.

Sustainability

To have long-term impact, the efforts described in this plan must be sustainable. The partnerships described in this plan are, in part, intended to provide the capacity, or "critical mass," needed to build a sustainable arthritis program in Utah. Efforts to identify individuals and/or organizations with the skills, passion, and resources needed to lessen the burden of arthritis in Utah are ongoing. One thing is clear, this program will not succeed without partnerships. Identifying and nurturing these partnerships will be the number one ongoing priority of the Utah Arthritis Program.

Potential Barriers to Success

While there may be potential barriers to the success of this plan, none of them are insurmountable and they must be viewed as an exciting opportunity. Perhaps the most obvious barrier is the fact that there has never been a coordinated, community based approach to lessening the burden of arthritis. In addition to the challenges associated with identifying and establishing partnerships for the first time, there are other issues making this coordinated approach a challenge. Some of these include a lack of public knowledge about the conditions and their risk factors, a lack of awareness that "something can be done" about the conditions, under-utilization of effective arthritis self-help programs, and limited understanding by decision-makers about the social and financial burden of arthritis. These challenges and others are presented in **Appendix A.**

Also in **Appendix A**, we contrast arthritis with another chronic condition, cardiovascular disease (CVD). This contrast is intended to demonstrate some of the challenges faced by arthritis programs and to highlight the enormous progress other, more established, chronic disease programs have made. We must focus on the opportunities for improvement. Relatively recently there were similar barriers present to improving CVD outcomes. While some challenges remain, those working in CVD have made enormous gains in recent years. These barriers have, one by one, largely been overcome and documented improvement in care is the result. There are no reasons to believe this will not also be the case with arthritis. It is important to note that many of these issues are related to the Healthy People 2010 arthritis-related objectives. Therefore, many of the goals of this plan are based on, and support performance improvement in these areas. The arthritis-related Healthy People 2010 goals are presented in **Appendix B.**

Utah's Arthritis Plan Development Process

Upon receiving funding from the CDC, a planning and implementation process began. Key individuals within the arthritis community were invited to participate on an Arthritis Advisory Committee. Advisory committee members are listed in **Appendix C**.

Arthritis Advisory Committee members were asked to serve on sub-groups to focus on specific topics included in Utah's Arthritis Plan. These topics supported the National Arthritis Action Plan (NAAP) and included: 1) Increasing community awareness; 2) Measuring arthritis trends; 3) Improving clinical practice; and 4) Promoting supportive health systems & policies. These sub-groups helped identify priorities, direction, and opportunities related to outcomes in each of these four areas.

Utah Arthritis Community

Persons with Arthritis	Professional Organizations	Voluntary Organizations	Public & Private Insurance Agencies
State and Local Health Agencies	Medical Association	Academia	Legislators
Hospitals	Community Health Centers	Ethnic Representatives	Self-Management/ Education Program Vendors
Arthritis Foundation	Centers for Aging	Seniors	Medical Providers

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Utah Arthritis Advisory Committee

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Four Sub-Groups

Increasing community awareness

Increase awareness of risk factors/signs/ symptoms

Increase access to educational materials

Increase use of self-help courses

Increase general arthritis awareness

Increase awareness of treatment options

Measuring arthritis trends

Continue to refine arthritis definition

Evaluate existing data sources

Gather missing data

Develop and distribute arthritis reports

Utilize data to focus program resources

Improving clinical practice

Partner with providers

Increase CMEs/CEUs

Increase academic offerings

Implement practice guidelines as appropriate

Conduct quality improvement pilot projects

Promoting supportive health systems & policies

Obtain and analyze health systems data

Use data to educate insurers

Promote disease management

Strengthen community coordination

Assess medical practice/ quality of care

Mission, Vision, and Outcomes

Our Mission

To increase the quality of life among persons in Utah affected by arthritis.

Our Vision, for the Years 2002-2006, is that all Utahns will:

- Be aware of the impact, seriousness, and ability to treat arthritis;
- Recognize chronic joint symptoms as a concern;
- Be proactive in seeking care for their arthritis;
- Be able to access proven effective self-management programs;
- Have less disability and pain from arthritis.

We envision a sustainable, long-term arthritis public health program that will:

- Secure and direct resources to build or strengthen programs or activities for communities, agencies, and health care providers;
- Foster a community which recognizes and supports, through funding and in-kind contributions, continued efforts to improve arthritis-related outcomes.
- Implement and coordinate a process for collaborative, innovative arthritis initiatives among agencies, health plans, communities, and health providers to continuously improve our collective efforts and arthritis-related outcomes;
- Collect, analyze, and disseminate data regarding arthritis prevalence, risks, and care throughout Utah and the nation;
- Offer consultation, technical assistance, evaluation, and reporting in the development of arthritis outreach/education projects, clinical quality improvement projects, and other community collaborative projects.

Measurable Outcomes

These activities support individual, community, and collaborative efforts towards impacting arthritis-related and overall health. This leads to measurable improvement in:

- The public's awareness about arthritis, the fact that it is treatable, and that it has defined risk factors;
- Participation in arthritis self-management, self-help, and physical activity courses throughout Utah;
- Provider utilization of arthritis education materials and referral of patients into the above programs;
- Decision-maker support of arthritis awareness and management efforts;
- Community and agency networking;
- Public and private partnerships to increase awareness and utilization of management efforts;
- Diverse and innovative arthritis programs that meet the needs of local and high risk populations;
- Decreased limitation of activity due to arthritis and increased quality of life in those with arthritis.

OBJECTIVES AND STRATEGIES

I. Increasing Community Awareness

Community education and communication are key components for addressing arthritis in Utah. Prevailing myths and misinformation dominate current arthritis information. While arthritis is common in older people, the disability associated with these conditions does not need to be as extensive as it presently is. Fortunately, there are many effective treatments for arthritis. Unfortunately, most individuals and many of their physicians are unaware of current treatment options and community resources that can reduce the pain and disability associated with arthritis.

This portion of Utah's Arthritis Plan strives to increase awareness, develop effective partnerships, increase media coverage, and increase use of proven arthritis education programs. Ultimately these actions will improve the quality of life for people affected by arthritis.

ISSUE ONE

Very few people realize arthritis is a serious public health concern. "Arthritis limits the daily activities of more that 7 million people, making it the leading cause of disability in the United States." As the "baby boomers" age, the impact of arthritis is expected to increase dramatically. By 2020, 60 million Americans, or almost 20% of the population will be affected, and more than 11 million will be disabled."

Current Utah Behavioral Risk Factor Surveillance Survey (BRFSS) data show that nearly one third of Utahns have arthritis or chronic joint symptoms.

RECOMMENDATION

Develop a strong Utah Arthritis Program that will utilize and coordinate local resources to increase public awareness about arthritis as a serious public health concern.

GOAL

Improve the quality of life for Utahns affected by arthritis, by increasing awareness of the impact, seriousness, and treatability of arthritis.

Objective 1: Partner with key parties involved in the health of individuals with arthritis.

Strategies:

- Utilize research information to identify appropriate partners, messages and locations to disseminate information.

- Partner with the Arthritis Foundation (AF) to increase general awareness of arthritis related issues.
- Involve local health departments in arthritis awareness/education.
- Partner with key individuals in the ethnic community to identify appropriate actions for minority populations.
- Partner with major employers to include arthritis information at in-house safety seminars/ education days.
- Identify one or more pharmaceutical companies that will contribute financially to increase production and distribution of educational materials.
- Partner with physicians, physician's assistants, nurse practitioners and other health professionals to disseminate information to patients while they are in the office.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- The Utah Arthritis Program will have established working relationships with key parties involved in the health of individuals with arthritis.

Objective 2: To develop and distribute a comprehensive, useful state plan.

Strategies:

- Develop a comprehensive state plan with input from interested parties.
- Distribute the state plan to individuals and organizations that would benefit from it.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- A comprehensive state plan will exist, copies will be distributed, and effect will be evaluated.

Objective 3: Partner with UDOH Health Promotion Programs for mutual benefit.

Strategies:

- Provide other health programs with arthritis information to disseminate to their public contacts.
- Provide information from other health promotion programs to our public contacts.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Evidence of partnerships will exist and results will be documented and evaluated.

Objective 4: To receive media coverage in the form of television, newspaper, and radio at least four times a year.

Strategy:

- Create standard media packets to be dropped off, four times a year, at local media venues by local contacts.
- Develop and implement arthritis radio campaign

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Media coverage by television, radio, and print will be evident.
- Call Volume to the UAF and Arthritis Foundation will increase.

ISSUE TWO

There is a lack of arthritis self-management resources and current resources are underutilized because of lack of awareness and misinformation. Historically, many people think nothing can be done to treat arthritis. Fortunately, there are many effective treatments for arthritis. Unfortunately, most individuals and many of their physicians are unaware of current resources that can reduce the pain and disability associated with arthritis.

The Arthritis Foundation (AF) has been a resource in Utah since 1956. The AF offers a variety of resources to individuals, including physical fitness and Arthritis Self-Help Course, (ASHC). The ASHC is an evidence-based intervention that increases self-management behaviors, improves cognitive pain management techniques and reduces pain. Studies indicate that pain is reduced by up to 20 percent. The ASHC is utilized by less that 1% of persons with arthritis.

RECOMMENDATION

Increase the visibility, access and availability of arthritis resources in Utah, including rural areas of the state.

GOAL

The UAP and the AF will develop health communications to enhance the knowledge, attitudes, beliefs and behaviors about arthritis self-management strategies, self-help courses,and physical activity courses among Utahns with arthritis and/or chronic joint symptoms.

Objective 1: Develop a comprehensive marketing plan for arthritis awareness, education and self-management.

Strategies:

- Conduct research to evaluate current knowledge, attitudes, and beliefs about these resources in people with arthritis and in providers of care.
- Collaborate with the AF, LHD's, and others to create marketing plans and resources.
- Develop and distribute new or current educational resources to partners.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- UDOH, AF, LHD's and others will utilize a marketing plan based on research findings and identified needs.

Objective 2: Increase the number, visibility, and utilization of educational and management programs available to persons with arthritis.

Strategies:

- Utilize the existing AF programs by making them easily available to care provider's health educators and persons with arthritis.
- Develop a resource guide that will provide an overview of all arthritis resources available statewide. Update it yearly.
- Partner with the AF to provide a bi-annual open house to inform care providers about available resources.
- Develop an interactive website that will link visitors to local arthritis resources.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- There will be an increase in AF programs available with increased participation

Objective 3: Increase the number of active trained lay leaders for ASHC, initially focusing on Salt Lake County and Tooele County Health Department and then expanding to others.

Strategies:

- Contract with Tooele County Health Department and the AF (for the Salt Lake Valley area) to identify, recruit and train lay leaders.
- Increase trained leaders in Salt Lake County from 20 to 40 and in Toole from 0 to 10.
- Identify other local health departments with which to partner.
- Work with local Universities to offer college credits to physical therapy/nursing students who are trained as self-help course leaders.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Evidence of 40 and 10 lay leaders in Salt Lake Valley and Tooele county respectively.
- Increase total lay leaders in Utah.

Objective 4: Begin self-help courses in Tooele County and in Salt Lake County with new lay leaders, and expend to other areas of Utah, including rural areas.

Strategies:

- Coordinate with LHD contacts to utilize a customized marketing plan to recruit participants.
- Explore opportunities to incorporate self-help into higher learning organizations.
- Explore opportunities to incorporate self-help into senior centers.
- Establish a partnership in southern and central Utah counties which have significant minority and ethnic populations.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Evidence of ASHC taught by new lay leaders.
- Evidence of partnership with southern and central Utah counties.

Objective 5: Implement and expand arthritis self-help programs in other parts of Utah.

Strategies:

- Utilize the findings from the self-help projects in Tooele and Salt Lake Counties to refine and implement similar efforts in other parts of Utah.
- Share these findings with other Local Health Departments, when adequate resources are available, to expand self-help programs in these regions.
- Continue focus on Southern and Central Utah as noted in Objective 4.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Increased ASHC taught and increased participation in these courses throughout Utah, including the rural counties throughout the state.

II. Measuring Arthritis Trends

Collection of arthritis data is critical for understanding arthritis, targeting populations, designing intervention, developing policies and setting priorities. These data will allow for a description of who is affected, what behaviors increase the risk of developing arthritis, and how the disease affects physical health and quality of life. These data will also help focus the use of limited public health resources in more effective ways.

The Utah Arthritis Program will serve as the clearinghouse for these data. The program will distribute data to public and private health care providers, the Centers for Disease Control and Prevention, the Arthritis Foundation Utah/Idaho Chapter, the Utah Arthritis Advisory Committee, health policy makers, third party payers, and individuals affected by arthritis. By sharing these data, we intend to educate about arthritis and ultimately impact arthritis prevalence and disability due to arthritis.

Data sources used include the:

- BRFSS
- Supplemental follow-up BRFSS Survey Questions
- Utah Hospital Discharge Database
- Medicare claims data
- Medicaid claims data
- Data from inpatient and outpatient claims records from managed care facilities
- The National Health Interview Survey (NHIS)
- The National Health and Nutrition Examination Survey (NHANES)

To develop an arthritis measurement and reporting system, the Arthritis Program will focus on the following goals, objectives and strategies:

ISSUE ONE

A data collection system to measure the occurrence, progression and impact of arthritis in Utah has not existed. Therefore, data about arthritis in Utah are limited.

RECOMMENDATION

A data collection plan must be developed to:

- Identify available sources of arthritis data
- Accurately measure the occurrence of arthritis in Utah; and
- Track the occurrence and impact of arthritis in Utah over time.

GOAL

Establish and maintain a measurement and reporting system in the Utah Department of Health for collecting and analyzing data describing arthritis in Utah.

Objective 1: Develop a plan for collecting arthritis data, which includes data sources, data collection frequency and methods of data analyses.

Strategies:

- Define data needs based on program objectives and input from data users.
- Identify and prioritize existing data.
- Identify and prioritize gaps in available data.
- Find/develop solutions to fill gaps in data.
- Identify methods for analyzing data.
- Identify potential users and uses of these data.
- Identify who will collect the data and how often.

Outcome Measure

When the objective is achieved, the following measurable outcomes will be evident:

- A data collection plan will be in place for measuring and reporting arthritis data.
- Data will be used to develop the priorities and policies of the Utah Arthritis Program.

Objective 2: Maintain historical data to evaluate trends in the prevalence of arthritis and changes in the health status of persons with arthritis.

Strategies:

- Continue using the BRFSS Arthritis and Quality of Life and Care Giving modules.
- Review BRFSS data biannually.
- Maintain the data measurement and reporting system for arthritis.
- Utilize these data to educate the public, including health care professionals and decision makers about arthritis.

Outcome Measure

When the objective is achieved, the following measurable outcomes will be evident:

- BRFSS data describing arthritis in Utah will be collected and analyzed biannually.
- These data will be presented in an arthritis report.
- These data will also be presented in "BRFSS Brief" and will be distributed to all partners and interested parties.

ISSUE TWO

Data describing the risk factors for arthritis in Utah have not been collected.

RECOMMENDATION

Utilize data resources to identify and report arthritis risk factors. The primary source of information for this effort will be the BRFSS survey.

GOAL

Identify people at risk for developing arthritis, and use these data to design strategies to reduce disability and to educate the public, including health care professionals, about these risks.

Objective 1: Use existing databases to identify potential risk factors for arthritis in Utah.

Strategies:

- Define data needs based on program objectives and input from data users.
- Identify existing data.
- Identify and prioritize gaps in available data.
- Find/develop solutions to fill the gaps in data.
- Identify methods for analyzing data.
- Identify potential users and uses of these data.
- Identify who will collect the data and how often.

Outcome Measures

When the objective is achieved, the following measurable outcomes will be evident:

- Data will be used to design strategies to reduce risk factors for developing arthritis.
- Data will be distributed in a "user-friendly" way to educate the community about these risks.

ISSUE THREE

Arthritis data should be used to guide program priorities and policies. It must be published in a report and distributed to key persons and organizations.

RECOMMENDATION

The Utah Arthritis Program should utilize and compile key arthritis data to produce a "Utah Arthritis Report". Also, a "BRFSS Brief" should be produced.

GOAL

Develop a "Utah Arthritis Report" to inform key people and organizations about arthritis prevalence and trends in Utah.

Objective 1: Analyze databases related to arthritis and compile the data in a document that is easy to read.

Strategies:

- Identify key data to be included in the report.
- Create a "Utah Arthritis Report".
- Evaluate the usefulness of the data by surveying those who receive the report.

Outcome Measure

When the objective is achieved, the following measurable outcomes will be evident:

- A document describing the prevalence, burden, and risks of arthritis in Utah.
- Survey results from those who receive the report.

ISSUE FOUR

Arthritis data needs to be disseminated to individuals and organizations that need to know.

RECOMMENDATION

The distribution of arthritis data should be coordinated by the Utah Arthritis Program to effectively use resources and avoid duplication. The "State of Arthritis Report" should be strategically distributed to key individuals, organizations, and the community.

GOAL

To disseminate arthritis data to key individuals and organizations that need to know, and that can influence arthritis support, knowledge, policies, and outcomes.

Objective 1: Develop methods to distribute arthritis data to key individuals and organizations.

Strategies:

- Identify key individuals and organizations to which the report should be distributed.
- Implement targeted distribution of the report to key individuals and organizations.
- Make the report available to the community at large.
- Announce/market the release of the report.

Outcome Measure

When the objective is achieved, the following measurable outcomes will be evident.

- Distribution of the data to key people and organizations.
- Distribution of the report to the public at large.

ISSUE FIVE

Because arthritis affects all community members, a data collection system must be developed to identify arthritis among ethnic and racial subgroups.

RECOMMENDATION

Develop a data system to track the occurrence, progression and impact of arthritis among ethnic and racial subgroups.

GOAL

To develop the capacity to collect and analyze arthritis data among minorities in Utah.

Objective 1: Devise methods to coordinate the collection, analysis, publication and distribution of arthritis data for ethnic and racial subgroups.

Strategies:

- Identify existing databases.
- Identify and prioritize gaps in available data.
- Find/develop solutions to the gaps in data.
- Identify methods for analyzing data.
- Identify potential users and uses of these data.
- Distribute a report describing arthritis among ethnic and racial subgroups in Utah.

Outcome Measure

When the objective is achieved, the following measurable outcomes will be evident:

- Data describing the prevalence of arthritis among ethnic and racial subgroups will be available.
- Completion of a report describing arthritis in ethnic and racial subgroups in Utah.
- Distribution of a report describing arthritis in ethnic and racial subgroups in Utah.

ISSUE SIX

Arthritis data are critical for understanding the disease and for targeting interventions, developing policies and setting priorities. To be effective, data and reports should be targeted and useful to diverse individuals, organizations, and agencies. Therefore, the measurement, collection, and reporting process should involve these partners from the onset

RECOMMENDATION

Establish a formal planning, measurement and reporting process with key partners. Foster these collaborative partnerships to explore the value of diverse data sources (e.g. Hospital Discharge Data, Medicare claims, Medicaid claims and other health plan data sources). Further foster these relationships such that the data are used to impact arthritis knowledge and care.

GOAL

Form partnerships with public and private organizations and programs interested in collecting and utilizing arthritis data to impact arthritis knowledge and care in Utah.

Objective 1: Develop and coordinate partnerships to engage in the collection of arthritis data to assess the burden of arthritis in Utah.

Strategies:

- Identify potential partners.
- Identify data needs of these partners.
- Identify existing data sources.
- Identify methods for analyzing and reporting data.
- Identify key individuals responsible for the process.
- Implement the process.

Outcome Measure

When the objective is achieved, the following measurable outcomes will be evident:

- Potential partners will be identified.
- Data will be gathered from other partners and analyzed on an ongoing basis.
- Data will be utilized to impact arthritis knowledge and care.

III. Improving Clinical Practice

Efforts to improve clinical practice include assessing provider knowledge/beliefs and practices, determining opportunity for improvement, implementing quality improvement programs, and monitoring changes in care as a result of these programs. These efforts should include those fitting the broad definition of "providers of care" to patients with arthritis. These professionals may include primary care physicians, rheumatologists, orthopedists, and non-physician providers of care such as physical therapists, nurses, and others.

It appears that many providers are not utilizing all effective treatment options. This is demonstrated by the very low utilization of proven arthritis self-help courses and physical activity courses. Also, little has been done locally to assess the current medical care for those with arthritis. This is particularly true with respect to primary care providers.

Additionally, little is known about the attitudes/knowledge of these providers with respect to the importance of arthritis diagnoses, the effectiveness of arthritis treatments, the use of arthritis medical care guidelines, or the effectiveness of arthritis self-help/education programs.

Provider education efforts should initially focus on the use of proven arthritis self-help courses and the assessment of provider beliefs and attitudes concerning these and other arthritis education resources. Also, efforts should be made to educate about the effectiveness of physical activity as a treatment for arthritis. Long-term efforts should include the assessment of current care provided to patients with arthritis and the distribution and application of arthritis care medical guidelines.

ISSUE ONE

It is clear that arthritis self-help courses, physical activity courses, and other arthritis education resources are underutilized. Results from focus groups in Utah women with arthritis, ages 40-64, indicate that providers do not recommend these courses to their patients with arthritis. It is unclear if the providers are unaware of the courses, do not believe them to be effective, or simply don't refer patients to them for other reasons.

RECOMMENDATION

Improve arthritis-related medical and social outcomes by increasing participation in arthritis self-help, physical activity, and education courses. This should in part be accomplished by increasing provider referral of patients into these courses.

GOAL

Increase participation in arthritis self-help, physical activity, and education courses through enhanced provider-based programs.

Objective 1: Determine the knowledge, beliefs, and attitudes of providers with respect to arthritis self-help courses.

Strategies:

- Conduct focus groups in providers to gain information about the above factors. Focus groups should be conducted in groups of primary care physicians, rheumatologists, and non-physician providers such as nurses and physical therapists.
- Conduct key interviews with providers to augment and perhaps support the findings from the above mentioned focus groups.
- Conduct a mail-based survey of providers along the Wasatch front to determine if the physician population supports these findings.
- Utilize findings from the above efforts when designing and implementing projects to increase participation in arthritis self-help courses.

Outcome Measure

When the objective is achieved the following measurable outcomes will be evident:

- Knowledge, beliefs, and attitudes of providers, with respect to arthritis self-help resources will be identified.
- These findings will be compiled in a report that will be useful for the Utah Arthritis Program, Health Departments in other states, and other interested parties.

Objective 2: Design and implement pilot programs intended to make resources available to providers of arthritis care that would encourage and support their efforts to include self-help and educational resources in their patient care.

Strategies:

- Convene groups of providers to determine their needs with respect to arthritis self-help and education resources.
- Evaluate existing resources to determine/identify those meeting the provider needs.
- In a small group of providers, pilot a program intended to increase their use of arthritis self-help and education as part of their normal protocol of care.
- Include information and resources intended to educate providers about arthritis self-help resources and focus on the effectiveness of these resources in pilot program.
- Following evaluation of this pilot, we may expand the program to include a larger population of providers.

Outcome Measure

When the objective is achieved the following measurable outcomes will be evident:

- An inventory of provider needs and available resources will be developed.
- Pilot programs will be developed, implemented, and tested.
- Impact on provider referral into arthritis self-help will be evaluated.

ISSUE TWO

There are currently no processes through which patient education, physical activity, and/or self-help needs are evaluated and matched to appropriate resources to meet these needs.

RECOMMENDATION

Develop a patient-based pilot program through which patient needs will be identified and matched to the appropriate education, physical activity, and/or self-help program.

GOAL

Improve the utilization of appropriate education, physical activity, and/or self-help resources.

Objective 1: Match patient needs to the resources available, and recommend these resources to the patient.

Strategies:

- Evaluate available resources and develop a "arthritis resource continuum" rating the resource on duration, depth of information, need targeted, and effectiveness
- Develop a needs assessment tool for patients
- Develop and implement a process through which patients needs are matched to the appropriate resource on the "arthritis resource continuum"
- Recommend the appropriate resource using an active process
- Develop a feedback mechanism whereby patients can communicate their experiences with the arthritis resources to their medical provider

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Patients will receive appropriate arthritis resources and providers will receive feedback about these resources from their patients.

ISSUE THREE

There are currently few, if any, provider-based programs to improve the quality of care in patients with arthritis.

RECOMMENDATION

Develop and test pilot programs to improve the quality of care in those with arthritis. Base these programs on accepted medical care guidelines for selected conditions. These efforts should focus on primary care providers.

GOAL

Improve the quality of care, as determined by medical care guidelines, in the patients of a pilot group of primary care providers.

Objective 1: Partner with a small group of providers, who are interested in improving the arthritis care given to their patients, to design and implement a quality improvement program for arthritis care.

Strategies:

- Identify approximately 10 primary care providers, throughout the Wasatch Front, to partner on the above objective.
- Identify the needs of these providers with respect to arthritis resources such as self-help courses, education materials, etc.
- Make a "grab bag" of core arthritis resources available to these providers, which they can utilize within their systems to augment the current care they provide to arthritis patients.
- Support the providers by providing innovative means of utilizing the resources, without added burden to their practices, such that results are optimized.
- Provide pre-printed scripts identifying arthritis resources. These would be checked and signed by the provider and sent to the patient.
- Continuously monitor performance of these programs to determine the effect on arthritis care and arthritis related outcomes.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Pilot programs will be initiated and, if effective, may be implemented on a larger scale.

IV. Promoting Supportive Health Systems & Policies

Unlike other chronic diseases, such as cardiovascular disease and diabetes, there is currently no clear application of systems and policy changes that would improve outcomes associated with arthritis. This isn't to suggest that there is nothing to be done. Rather, it indicates there is much to be done. In many respects, we are breaking new ground.

ISSUE ONE

Arthritis includes over 100 conditions and there is no clear consensus on which conditions should be included when defining arthritis. Adding to this problem is the fact that there are widely varying symptoms and treatments for many of these conditions. If we are to impact arthritis through health systems interventions, we must establish an accepted, validated, claims-based definition and a standard way of measuring the conditions.

RECOMMENDATION

Work with other parties involved in developing and validating claims-based arthritis definitions and measurement techniques. Contribute to this effort by gathering, organizing, and analyzing Utah arthritis claims data.

GOAL

Contribute to the development and validation of a nationally accepted claims-based definition of arthritis.

Objective 1: Make Utah specific arthritis claims data available to those involved in National arthritis definition development when requested.

Strategies:

- Work with health plans, Medicaid, Medicare, Peer-review Organization and others to gather arthritis medical claims data using a standardized set of ICD-9 codes.
- Conduct statistical analyses of those data to describe trends in medical utilization.
- Present findings to the above groups with the intent of refining analyses, educating decision makers in the groups, and addressing confidentiality concerns.
- Make findings available on request to those working to establish a nationally accepted definition of arthritis. All data would be blinded and members or health plans would not be identified.

Outcome Measure

When the objective is achieved the following measurable outcomes will be evident:

- Claims data will be gathered, analyzed, and reported in a usable format.
- Information will be provided on request to the CDC and others who are working on these issues on a national level.

Objective 2: Support standardized measurement and reporting of arthritis related claims data.

Strategies:

- Always emphasize the need to measure and report arthritis data using standard methods when working with/through the CDC.
- Always support the CDC with their efforts to establish standardized measurement and reporting methods by providing them with required information and collaborating in the planning process.
- During collaborative discussions and projects with other funded states always strive to encourage standardized measurement and reporting of arthritis related data.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

ISSUE TWO

It is difficult to improve when there are no accepted standards or indicators. Many chronic diseases have established indicators that aid in quality improvement efforts. The most widely accepted of these are the HEDIS (Health Employer Data Information Set) established by the National Committee for Quality Assurance. Health plans measure quality of care provided to their members by using these measures. The results are made public and employers use them to select health plans. Therefore, both health plans and providers of care have incentives to monitor these indicators and try and improve the care associated with the indicators. Unfortunately, no such indicators exist for arthritis care.

RECOMMENDATION

Work with and contribute to national efforts to develop and implement accepted quality indicators for arthritis care.

GOAL

Nationally recognized and accepted quality indicators for arthritis care will be developed and implemented.

Objective 1: Support national efforts to develop accepted quality of care indicators related to arthritis.

Strategies:

- Participate in and contribute to national dialogue with those who are working on developing quality indicators for arthritis.
- Utilize program expertise and quality improvement contacts to assess the viability of potential indicators within the Utah health care delivery system.
- Work with local providers and health plans to review potential indicators and provide feedback to the national indicator development team.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Utah will contribute to efforts to describe and develop reliable quality indicators for arthritis care.

Objective 2: Work towards implementing and utilizing quality indicators, following their development, to improve quality of care and assess changes in quality of care.

Strategies:

- Work with Utah health plans to begin to use these quality indicators as one indication of the overall quality of care received by their members.
- Work with Utah health plans to have these quality indicators added to their provider reports such that providers of care are aware of their own performance with respect to these indicators.
- Work with Utah providers and Utah health plans to implement quality improvement programs intended to help them increase the quality of care with respect to these indicators.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident.

- If such indicators are developed during the period of this plan, distribution and discussion of these indicators will be evident in at least a sample population of providers.

ISSUE THREE

While there are medical guidelines for appropriate care of those with arthritis, these guidelines are not widely followed and many primary care providers apparently are not aware of the guidelines

RECOMMENDATION

Support the distribution and implementation of accepted medical guidelines for arthritis care in Utah. These efforts should primarily be directed towards those providing primary care.

GOAL

Existing medical guidelines for the care in those with arthritis will be widely implemented in the primary care setting resulting in improved medical care.

Objective 1: Distribute and encourage implementation of medical guidelines in primary care of those with arthritis.

Strategies:

- Implement a pilot project in a small number of provider clinics to distribute and implement medical guidelines for arthritis care.
- Work with a local health plan to identify an application for a pilot project, using their data systems, to implement medical guidelines in a sub-population of providers.
- In these pilot projects monitor the care provided to patients to assess effectiveness of these medical guidelines in changing/improving quality of care.

Outcome Measure

When the objective is achieved the following measurable outcome will be evident:

- Distribution and discussion of medical guidelines will be evident in at least a sample population of providers.

ISSUE FOUR

Due to the issues mentioned above, there are currently few, if any, focused efforts to impact care and medical utilization using a "disease management" approach within the health care delivery system. Disease management programs for other chronic diseases such as CVD, diabetes, and asthma have shown to be effective in improving care and related medical outcomes. In addition to traditional medical office care, there are proven self-management programs for arthritis that could serve as one treatment option in a disease management approach to arthritis care.

RECOMMENDATION

Work with health plans and providers to address all of the above issues such that the "state is set" for implementation of disease management programs to improve the care and related medical outcomes for those with arthritis.

GOAL

Improve the quality of care and medical outcomes of patients with arthritis through a systems based disease management program for arthritis.

Objective 1: Work with a local health plan and providers to implement a pilot disease management program designed to improve the care and medical outcomes of arthritis patients.

Strategies:

- Work with the Arthritis Foundation, providers, health plan representatives, and others to assess the feasibility of implementing a disease management program for arthritis.
- Upon addressing the above issues, identify a local health plan and /or a pilot group of physicians willing to discuss the issues involved in implementing an arthritis disease management program.
- Utilize medical claims data to identify patients/members who have arthritis and who would potentially benefit from this program.
- Implement the program in a small group of patients meeting the above criteria.
- Continuously work with all parties to monitor the success of the program and evaluate/ implement changes to improve performance.
- If the program is effective, slowly introduce it to others so optimal benefits are realized.

Outcome Measures

When the objective is achieved the following measurable outcomes will be evident.

- At least one pilot program utilizing arthritis self-help and other education materials in a health-plan-based disease management program will be conducted.
- This effort will be made available to other state arthritis programs and similar National efforts.
- If effective, the program will be expanded to larger populations.
- Arthritis-related outcomes will be improved in individuals participating in these efforts.

Appendix A: Key Programmatic Contrasts Between Cardiovascular Disease (CVD, Heart Disease) and Arthritis

	Cardiovascular Disease (CVD)	Arthritis	Result
Is the public knowledgeable about the condition and its risk factors?	There appears to be a high general knowledge about the condition and risk factors for developing CVD.	There appears to be a low level of general knowledge and little understanding of many of the risk factors for developing arthritis.	Generally, little is done to improve or avoid modifiable risks.
Are individuals aware that "something can be done" about the condition?	The physical and behavioral risks are well documented and generally people know they can be modified.	Many individuals, even those with arthritis, view the condition as "part of aging." Few realize there are effective treatments and self-help programs.	Many with arthritis don't receive medical care and may not even be diagnosed. Also, very few utilize the self-help resources available to them.
Are education, support, and self-help programs well utilized and adequately resourced?	Generally, these programs are promoted and provided through the health care system. Paid instructors are often associated with a care facility. Utilization is relatively high.	Providers, clinics, or hospitals often do not promote programs. Volunteer instructors are generally not associated with the health care system and there are often too few instructors.	Individuals in need of these resources are not referred by their providers or care givers to them. The courses are poorly utilized. If demand were to grow substantially, it may be difficult to recruit an adequate number of instructors.
Are education, support, and self-help programs covered under insurance benefits?	Often programs such as nutrition, behavior modification, and physical activity are covered in the CVD patient.	Few if any of these resources are a covered benefit in most insurance plans.	There is reduced incentive to take self-help and other education courses if there is a direct cost to the patient.
Is the condition well defined?	There is little dispute about what conditions constitute CVD.	Arthritis is made up of over 100 conditions. Many people are confused about what is meant by the term "arthritis."	Insurers and others may not recognize the conditions as priority. Also, multiple definitions make community awareness more challenging.
Are there widely accepted and measurable quality of care indicators?	Examples are cholesterol management and beta-blocker treatment after a heart attack.	For many conditions there are no widely accepted quality of care indicators and none that are systematically measured.	Difficult to measure quality of care. Therefore, individual and population care is difficult to assess. Also, insurers don't view these conditions as potential areas to improve quality.
Are there widely accepted and implemented medical guidelines for the condition?	Accepted medical guidelines appear to be widely utilized.	Guidelines are available for relatively few conditions and use of these appears to vary by provider type.	Care may not be as good as it should be. Also, it is difficult to assess and improve arthritis quality of care.
Are the public and decision-makers aware of social and financial costs of the condition?	CVD is recognized as having high social and financial costs.	Due to many of the above noted issues, it is difficult to accurately measure and communicate costs.	Relatively few individuals or organizations view arthritis as a priority.
Are there proven systems-based disease management programs for the condition?	Because of standardized measurement, documented burden, quality indicators, and medical guidelines, systems are in place to improve care.	Because of many of the limitations noted above, there are very few examples of systems-based disease management programs for the conditions.	While efforts are made to improve care patient-by-patient and clinic-by-clinic, there are few if any efforts being made to improve care across the population of individuals with arthritis.

Appendix B: Healthy People 2010 Arthritis-Related Objectives

Arthritis, Osteoporosis, and Chronic Back Conditions

- Increase mean days without severe pain for U.S. adults with arthritis to more than 20 of the last 30 days
- Reduce to no more than 15 percent the proportion of people with arthritis who experience a limitation in activity due to arthritis.
- Reduce the proportion of all people with arthritis who have difficulty in performing two or more personal care activities, thereby preserving independence.
- Increase the proportion of people with arthritis age 18 and older who seek help in coping with personal and emotional problems.
- Increase the proportion of the working-age population with arthritis who desire to work (i.e., both those who are employed and those who are unemployed but looking for work, called the labor force participation rate) to 60 percent.
- Reduce racial differences in the rate of total knee replacements for severe pain and disability.
- Decrease to 5 percent the proportion of individuals who report they have arthritis but have not seen a doctor for it.
- Increase the early diagnosis and appropriate treatment of individuals with systemic rheumatic diseases.
- Increase the proportion of people with arthritis who have had effective, evidence-based arthritis education (including information about community and self-help resources) as an integral part of the management of their condition.
- Increase the proportion of hospitals, managed care organizations, and large group practices that provide effective, evidence-based arthritis education (including information about community and self-help resources) as an integral part of the management of their condition.
- Increase the proportion of overweight people with arthritis who have adopted some dietary practices combined with regular physical activity to attain an appropriate body weight.

Physical Activity and Fitness

- Increase to 85 percent the proportion of people age 18 and older who engage in any leisure time physical activity.
- Increase to at least 30 percent the proportion of people age 18 and older who engage regularly, preferably daily, in sustained physical activity for at least 30 minutes per day.
- Increase to at least 25 percent the proportion of people age 18 and older who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.

Nutrition

- Increase to at least 60 percent the prevalence of healthy weight (defined as a BMI equal to or greater than 19.0 and less than 25.0) among all people age 20 and older.
- Reduce to less than 15 percent the prevalence of BMI at or above 30 among people age 20 older.

Appendix C: Utah Arthritis Advisory Council

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